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A COURSE OF CLINICAL LECTURES,

Delivered at the Hôtel Dieu, Paris, for the Session 1842-'43.

BY A. F. CHOMEL, M. D.

LECTURE VII.

HYSTERIA—RAMOLLISSEMENT.

At No. 4 of the Salle Saint-Bernard you will find a young girl, of strong constitution, who was brought to the hospital about eight days since in nearly a comatose state. She was suffering from a nervous attack which had just seized her, and the characters of which we will now proceed to examine, as some interesting circumstances were connected with it, which complicated it, and rendered the diagnosis by no means easy.

On her entrance into the hospital she was insensible, or rather she appeared unconscious of what was going on around her, without being, at the same time, in a state of actual coma. Finding that there was no immediate danger, and that the affection was only nervous, probably hysteria, we abandoned the patient to the unaided efforts of nature, limiting ourselves to recommend to those in charge of the service the necessary watch to prevent accident. However, on seeing such attacks in a young girl, in such apparent robust health, we subsequently began to suspect that there might be something more than simple hysteria; to satisfy ourselves on this point, we availed ourselves of a moment of remission and calm to question the patient upon some points of her antecedent history. She gave us in answer the following details.

She is a mantua-maker by trade, and has inhabited Paris for a short time only, living before in the country. Her present affection first appeared at sixteen years of age, and was attributed by her to the following circumstance: One day, whilst in the fields, at some distance from home, she was attacked by a dog, who did her no bodily harm, but frightened her excessively. As soon as she returned home she immediately experienced in her whole body irregular, involuntary movements: in fact, genuine convulsions. The termination of this first attack was followed by an acute affection, with nervous symptoms, which yielded to appropriate treatment. These nervous symptoms were renewed for two years at irregular intervals, but always without fever. At nineteen years of age she had, for the first time, her catamenia; and in spite of the establishment of this new function, the nervous phenomena continued, and appeared even to augment. These periodical attacks finally exposed her, as so often happens in small places, to isolation, and to the reproaches of her neighbours, which finally induced her to quit her native spot and settle in Paris. Arriving here, she soon entered a shop as an attendant, but her nervous attacks again recurring, and so violently and constantly, that she determined on quitting her employment and becoming a seamstress—an occupation which enabled her to take better care of herself, and to hide her attacks from the public eye. Nevertheless the attacks continued, their frequency and intensity increasing. We have asked her if she was attacked indiscriminately, wherever she might be, in spite of herself, and without her being able to oppose them. She answered that she was constantly attacked out of doors, in public, without its being in her power in any manner to prevent them: she told us that during the attacks she saw and heard all that passed around her, but without being able to indicate her consciousness.

At the commencement of the attack she experiences a violent pain in the epigastric region, which gradually ascends towards the throat, impeding respiration; and she then falls without apparent consciousness. At other times a spasm seizes the throat, suffocating her, and is followed by convulsions. Since the invasion of these attacks her disposition has materially changed; she has become very impressionable; the slightest opposition excites her, and produces an attack. Menstruation does not seem to exercise any marked influence upon the production of these accidents, for they frequently occur at the menstrual period and continue throughout. After an attack has taken place, her mouth ordinarily remains a little drawn to the left side; there is some degree of hesitation in the speech; at the same time there is some *géne* in motion, with a little obtuseness in sensibility. This diminution in sensibility and motion is more marked in the left side of the body than the right. It seems to me also that she sustains herself less well on her left leg than on her right. She sometimes has violent cephalalgia, principally at the top of the head.

All these symptoms induce us to believe in an hysterical affection, but complicated with an epileptiform tendency. These attacks seize her suddenly, in the midst of the street, and wherever she may be, without her being able in any manner to prevent them, or to moderate their intensity. This circumstance militates strongly in favour of the epileptiform character of the complaint, and hence results the suspicion of an organic affection of the brain, which probably is its cause. It is almost unexampled for an hysterical woman to have a paroxysm in the street, and in places where she may be exposed to the public gaze. Hysterical paroxysms can always be voluntarily adjourned, or at least for a sufficient length of time to permit those who are attacked by them to retire into privacy; whilst attacks of epilepsy are instantaneous, and entirely involuntary.

The attacks, then, from which this patient suffers, are of the nature of epilepsy, and consequently, we should admit in her the probability of a cephalic lesion—for they are almost invariably due to the presence of a tumor in the brain, or of a cyst compressing some portion of the nervous matter.

Much is to be apprehended from the sequelæ of these attacks. This kind of complication of hysteria and epilepsy is by no means assuring.

It has been said that sexual appetite is one of the

determining causes of hysteria, and that it most frequently occurs in women who are deprived of sexual indulgence. Hence, the cure has been found in the union of the sexes. Now I regard this view as altogether erroneous. You constantly see attacks of hysteria in married women, and they are not rare in prostitutes, and in women who commit more or less venereal excess.

On the other hand, you constantly meet with hysteria in women who are a prey to some mental suffering; in young women who are married against their will, or in girls who have been disappointed. From these circumstances one is led to regard hysteria more frequently as rather the result of moral influences than physical causes. Finally, some women fall into hysteria at the moment of coition, so that in these you are unable to produce at all venereal excitement, without a paroxysm.

I regard, then, hysteria, in a word, as a disease essentially nervous, altogether independent of uterine influence, and which may occur as well in the male as the female, if the impressionability of the nervous system of the two sexes were the same. But the different temperament of man, the greater sturdiness of his character, and his inferior excitability, predispose him rather to hypochondria, which in him seems to be analogous to hysteria in the female.

As to our patient, you see manifestly that in her the hysteria was produced by a moral cause, by violent fright, which gave a great shock to her nervous system. We questioned her with regard to the fact of her ever having had sexual relations, being induced to do this from the fact which I mentioned above,—from the popular prejudice which many physicians follow, which regards them as salutary in this class of affections. She answered in the affirmative, adding that it had been by the advice of her physician. I do not here wish to enter into any discussion regarding the question of morality, although this is a question of great gravity, but will content myself with saying that such advice is absurd, and as prejudicial in a physical point of view as in a moral. How can you foresee to what this advice may lead; and besides, how many women are there to whom sexual intercourse is positively injurious! No physician, who respects himself, should ever attempt to give such advice.

At No. 1 of the Salle Saint-Agnes you have remarked a strong, robust man, of about forty years of age, suffering from a grave affection. Twenty years ago he had a severe attack of articular rheumatism in his left elbow, which yielded, however, to appropriate treatment, without leaving any apparent trace of disease of the heart. For the last ten years he has habitually suffered from severe pain in the head, the intensity of which, however, varied. There is sometimes deviation of the mouth to the left side, at the same time that his left arm becomes more feeble than his right. These symptoms, which were in a measure remittent, augmented in intensity within the last four years, during which time he has remained in a constant state of dizziness, with general feebleness, more particularly of the left side of the body, which have prevented him from attending to his occupations. About two years since he had a fall on his side, which obliged him to remain in bed for two weeks, at the end of which time he believed himself entirely recovered; but soon afterwards his former symptoms returned, and made slow but sensible progress.

On the 20th of last September he had abundant diarrhœa, with vomiting; the cephalalgia and other cerebral symptoms continuing to manifest themselves. In this state he entered the Hôpital Cochin, which he soon left, without any notable improvement. He subsequently entered several other hospitals, but continued in the same state, complaining constantly of the cephalalgia and of the feebleness. Finally, about the commencement of October, he had an attack of epilepsy, which was renewed several times, and in which the convulsive movements occurred over the whole right side of the body. After the first attack he entered our service.

On his entrance his answers were vague, incoherent, and unsatisfactory; his physiognomy stupid, his eyes haggard; there was evidently a good deal of derangement in the intellect; the cephalalgia and the feebleness of the left arm and leg continued to progress. At this epoch both pupils were equally dilated.

On the 1st November he had another epileptic fit, during which convulsions occurred only in his left arm. This attack was followed by an attack of somnolency, which lasted some hours. From this time the feebleness rapidly increased, and his sight, which hitherto had been good, now became so much impaired that he could hardly distinguish objects.

In this condition the patient remained, without any apparent change, for nearly two months, when, at the visit a few days since, we found him in a state of stupor, from which nothing could rouse him. We found, on inquiry, that several times previously he had been similarly attacked, but that after a short time he recovered. Believing, consequently, that he was only suffering from an habitual attack, from which he would soon recover, we did not pay any particular attention to him. But the day following we found him in the same state; he was motionless and insensible to all external excitement; his eyes were open, but totally insensible to light. His left arm, on being raised, fell like an inert mass. In the right arm some degree of muscular contractility seemed to remain. All the usual means, as sinapisms, &c., had been tried without result. There were the evident symptoms of an acute affection being added to the chronic one already existing; either an inflammation of the substance of the brain developed around some primitive lesion, or a serous effusion producing compression. The primitive affection was either a tumor or softening, or a chronic phlegmasia of the membranes. At the expiration of the fourth day the patient fell into complete coma and died.

On examination, after death, we found an encysted tumor of the size of a hen's egg, with thin walls and filled with an opaque serous fluid, occupying the anterior part of the left cerebral hemisphere, but so near the mesian line, that it pushed somewhat the septem lucidum to the opposite side. This tumor was divided into two parts; one, the most voluminous, situated anteriorly; the second, smaller, posteriorly. Between these tumors there was a kind of strangulation, formed by a bridle, which separated completely the two tumors. In the smaller one was found an hydatid, in a collection of serum. The cerebral mass was softened to a considerable extent around the cyst. The seat of this tumor so near the optic thalami, and the origin of the motor nerves of the eye, explains the loss of vision; but the hemiplegia is not so easily accounted for, without it were due to the softening of the cerebral mass.

Paris, February, 1843.

QUARTERLY REPORT

OF THE

OBSTETRIC DEPARTMENT OF THE PHILADELPHIA DISPENSARY,

For First, Second, and Third Months, 1843.

By Joseph Warrington, Obstetric Physician.

Forty-four women have been delivered, all at or near the full term of utero-gestation except one, in which the ovum having been developed to the sixth month, was expelled at the termination of the seventh.

The average duration of labour, in thirty-nine cases, was fifteen hours, twenty-six minutes; the extremes being one and a half, and sixty-four hours.

The average amount of time required for the spontaneous delivery of the placenta, in thirty-seven cases, was ten minutes; the extremes being five, and sixty minutes.

Manual assistance was afforded for the delivery of this mass in three instances, in which the disk presented so large a surface to the orifice of the uterus that it could not pass through it until one edge was drawn down by the finger after the patient had made ineffectual effort for extending it, in one instance fifteen minutes, another at twenty-five, and the third at forty-five minutes subsequent to the expulsion of the fetus.

Forty-five children have been delivered, one woman having twins.

Twenty-nine of these children were males, and sixteen were females.

The vertex of the cephalic extremity of the fetal ellipse presented in thirty-two instances; of these, nineteen were in the first position, and seven in the second.

One child, developed to the sixth month, but born at the end of the seventh, presented the breech in the fifth position.

One of the doublets presented the dorsum; it was converted by the use of a hand into the second position of the breech.

The umbilical cord was noted in one case to be about one-half the usual length, measuring ten inches.

One child had a slight deformity of the pedal articulation, for the correction of which appropriate dressings have been applied.

One child also had exomphalos, which is improving rapidly under a compress and roller.

The os uteri in one case, during the first stage of labour, continued so rigid as to render free bleeding necessary to promote relaxation.

There were two instances of irregular contractions of the uterus for about two weeks before the termination of labour; in one of these the os uteri was observed to be partially dilated about eight days previous to delivery.

In the second stage of the labour, the entire duration of which has been noted to be sixty-four hours, forty grains of ergot were administered, without, however, any marked effect in increasing the expulsive action of the uterus.

The forceps was used in one case to deliver from the superior strait of the pelvis a child, the occipito-mental diameter of which measured seven, the occipito-frontal six, the biparietal three and a half, and occipito-bregmatic three and a half inches.

This instrument was used also in a primiparous female, for the delivery of a child, the head of which had become arrested at the inferior strait. The child weighed ten and a half pounds.

There were three instances of hemorrhage after delivery. Free friction, regular compression, and the ergot, in tincture or substance, were resorted to. The flow became speedily arrested in two cases; in the third, however, the atony of the uterus was so great, that its contractions could not be reproduced until the hand had been introduced to stimulate its internal surface. Recovery was rapid in the two first instances; but in the third the patient suffered much from the usual consequences of excessive loss of blood for several days.

There were five cases of attacks of inflammation of the peritoneum, uterus or its appendages, after delivery. In three of them the disease was quickly arrested by prompt and free venesection, cathartics, and anodyne diaphoretics. One continued through a number of days, though actively depleted, both generally and locally, and one resisted the action of all treatment.

The patient was badly accommodated in one of the densely inhabited houses on the bank side of Front street, and had suffered much from moral and physical causes, both before and subsequent to her parturition.

She died on the sixth day after delivery.

All the other women recovered.

Nineteen of the cases above reported have been attended by nurses in the employment of the Nurse Charity Society; and we continue to be persuaded that much benefit is conferred upon most of those who derive such aid.

CLINICAL LECTURES AND REPORTS.

UNIVERSITY OF PENNSYLVANIA.

CLINIC OF DR. W. POYNTELL JOHNSTON.

At the Locust Street Dispensary, April 12, 1843.

[Reported by Daniel C. Holliday.]

Case I.—*Varicose Veins of the Left Leg.*

Bernard Camppe, aged 35, strong constitution, by trade a carter, and accustomed to use the left leg in digging, has perceived for a number of years a gradual increase in the volume of the left saphena vein; about the same period he experienced occasional pains along the course of the right sciatic nerve, which gradually occurred more frequently, and were of longer duration; while, at the same time, he noticed a swelling in each iliac region, which he attributed to the constant jolting of the cart, and the weight of the bowels.

Upon examination at the clinic, the left saphena and all its branches were found in an extremely varicose condition, from the internal malleolus to its junction with the femoral vein; below the internal condyle the vein offered innumerable convolutions, several of which were collected into tumors of the size of a small egg. Above the condyle the vein was tortuous, very much enlarged, and when grasped between the fingers, offered almost the resistance of cartilage, so much were the coats thickened; at the point of junction with the femoral the saphena appeared constricted, but above this point the femoral itself could be traced in a similar varicose condition, under Poupart's ligament, into the iliac fossa.

On each side of the rectus abdominis, above Pou-

part's ligament, appeared a projecting tumor, caused, it would seem, by the gradual distension of the combined tendons of the abdominal muscles at these points. When the patient assumed the erect position the abdominal viscera apparently fell forwards into these pouches, which disappeared when the patient was placed upon his back; in the recumbent position no tumor could be felt in the iliac regions, and the varicose appearance of the saphena was removed.

On the right side the patient complained of pain in the gluteal sciatic nerves, and he was able to trace with precision the whole course of this nerve, as giving him pain and causing numbness of the right foot. This pain was materially increased by coughing, or any effort producing mechanical compression of the lower part of the abdomen.

The saphena vein is not unfrequently rendered varicose in athletic individuals, by the constant state of tension in which the muscles of the leg are kept, from the nature of the occupations of such persons; two causes co-operate to produce this condition: 1st, a greater amount of blood than usual is attracted to the leg and foot by the constant exercise of their muscles; and 2d, the whole, or nearly the whole of this blood is required to be returned to the heart, against the resistance of gravitation by the saphena alone, because the satellite veins being compressed by the contracted muscles, are unable to perform their part. Under these circumstances the saphena dilates, its coats become thickened, and a permanent varicose condition is established.

This explanation, however, would not suffice in the case presented, although the occupation of the individual is such as might favour it. He is employed in digging cellars, and while digging uses the left leg; but the varicose condition extends throughout the whole course of the saphena vein, and beyond this along the femoral vein into the iliac region. Now it is obvious that the cause of obstruction to the circulation in the veins of the left lower extremity must be sought at some point between the commencement of the dilation and the heart. It cannot be supposed to exist in the vena cava itself, because the veins of the opposite extremity are unaffected; it should, therefore, be found between the cava and the femoral, that is to say, in the iliac fossa. The tumor formed in this region by the imperfectly supported viscera, offers a probable cause of compression of the left iliac vein, which would abundantly account for the symptoms exhibited.

On the right side a similar tumor exists, and yet the vein has escaped; it has escaped, however, at the expense of the ischiatic plexus of nerves, causing cramps and pain along the course of the gluteal and sciatic nerves of this side.

The various methods of treatment for this condition of the veins, which is apt to produce and maintain an indolent ulcer of the leg, were described.

They consist of the ligature, the section, the excision and the compression of the vein.

The ligature of a vein is on high authority almost proscribed; still, this proscription must not be rendered too absolute; a healthy vein may frequently be tied with impunity, while the ligature of a varicose vein, the coats of which are thickened and diseased, is too frequently followed by death. The same is true of all the operations which interest the lining membrane of a diseased vein. All these operations have a common object, the obliteration of the main trunk of the vein through the medium of a local inflammation. They all offer a common danger, that this local inflammation may generalise itself, and death ensue from a purulent phlebitis.

Independently of the danger to life of such operations, there is another objection, viz.; that they frequently fail of their object; 1st, because the obliteration of one or more trunks may only produce a similar varicose condition of those which remain, the original cause continuing. And 2d, because the obliteration itself is not always effected by the operation. Thus the operation of Brodie is frequently unsuccessful, because the two severed extremities of the vein may reunite, and even the ligature itself is not free from such a result.

In 1833 a man was admitted into the Hospital of St. Louis, in the service of Prof. Gerdy, for a varicose ulcer of the leg. Ten years before, for a similar ulcer, the saphena had been tied by M. Berard opposite the condyle. The account of the operation by the patient was clear; the application of the ligature—the day on which it came away—the effects upon the ulcer, which was cured, and remained so for seven years—were all accurately described; and to confirm the accuracy of his description, the vein was found constricted opposite the condyle; a cicatrix existed in this point, and yet the permeability of the vein was reëstablished, as could easily be recognised by placing a finger upon the vein above and below the strictured point, and causing the blood to flow backwards and forwards between the two.

The operation of Davat is less objectionable, as being less dangerous than those described, yet it is not devoid of danger; the first results of this operation were extremely flattering,—and although subsequent experience has shown that it is occasionally followed by fatal results, still the proportion of successful cases is so great that we are induced to look for some cause to explain the difference in result between this operation and those in which the lining membrane of the vein is directly interested. If a pin be placed beneath the vein and a twisted suture above it, the sides of the vein are brought in contact without lesion of its coats. Is it possible that under these circumstances the vein is obliterated without the aid of inflammation? that the complete arrest of circulation causes coagulation of the blood, and that the coagulum undergoes the same changes as would follow an entire arrest of circulation in an artery, viz., the absorption of the fluid particles and the organisation of the fibrin? That is to say, may the vein be converted thus into a solid cylinder and cease to be permeable, without the production of inflammation, and, consequently, without danger of general phlebitis?

In the case presented no operation can be performed, because the point of obstruction is in the iliac fossa, and beyond our reach. We must, therefore, be content to give to the varicose veins an artificial support, to compensate for that which they have lost by the gradual yielding of their own parietes. The limb was elevated to evacuate the distended vein. A bandage was applied from the foot to the groin, and then made to encircle the lower portion of the abdomen, so as to sustain the abdominal viscera. Cups were directed to the spine on the right side and along the course of the painful gluteal and sciatic nerves; the bowels to be kept free with the compound cathartic pill. Should the compression prove of essential benefit, a more permanent and efficient apparatus than a mere roller would be applied.

CASE II.—*Mucous Polypus of the Nose, removed by the Forceps.*

The patient, —— Robinson, ætat. 23, in the

joyment of excellent health, was attacked six weeks since with a cold in the head. From this period he stated that he had not been able to breathe through the left nostril, and had lost the sense of smell on the same side. He was sensible of an obstruction on the left side, which he endeavoured ineffectually to remove by continual efforts. During these efforts there could be perceived in the left nostril, by examination in a strong light, a pellucid, bladder-like mass, which moved backwards and forwards during inspiration and expiration. The volume of this tumor increased in moist weather; it was unaccompanied by pain or hemorrhage; and even when rudely touched with the finger or a probe did not bleed.

This was clearly a case of polypus of the nose, but polypi differ in character. The mucous membranes are liable to several varieties, and of each of these the Schneiderian membrane presents examples. There occasionally arises in the nostril a fleshy growth of a red colour, extremely painful, and bleeding spontaneously, or upon the slightest touch, constituting the fleshy polypus of authors. This species of polypus grows rapidly, and is highly organised, as is exhibited by its vascularity and the pain which is inherent to the tumor itself, and is not dependent on pressure upon the surrounding parts. This species is very apt to degenerate into cancer, and is probably a malignant growth from the commencement. From this form of polypus the case presented differed in every feature.

There is another species of hard polypus to which all mucous membranes are liable, but which is found most frequently in the womb, and occasionally in the nostrils or pharynx. It is fibrous in texture; not vascular; free from pain, except such as is produced by pressure upon the parietes of the cavity in which it is contained; susceptible of carcinomatous degeneration, although this is not of frequent occurrence; and when presented, generally occupies that portion which is most distant from the pedicle or base by which the polypus is attached, and does not occupy the whole tumour. When this degeneration exists the polypus may be accompanied by hemorrhage. With this variety, again, the case under examination could not be confounded.

There remained but one more species of polypus, viz., the soft polypus. With this variety, in its incipient stage, the case of Robinson corresponded entirely. The soft or mucous polypus presents the aspect, but for its colour, of a mere hypertrophy of the mucous membrane. When examined, however, by dissection, it is found to be devoid of bloodvessels, and to offer no trace of organisation. When removed, it resembles very accurately in appearance an oyster. The difference in the mode of growth of these different varieties of polypi, with their effects upon the parietes of the cavities in which they originated, were described, and the different methods of treatment commented upon. The case presented offered no peculiarity, except probably the rapidity of its growth, and corresponded accurately with the description of mucous polypus given by authors.

The polypus was then removed with the forceps; after which, by means of the instrument of Bellocque, a large pledget of lint was introduced into the posterior nares, and made forcibly to sweep the nostril from behind forwards, to remove any trace of the disease which might have escaped the action of the forceps.

In order to confirm the cure, and prevent a return of the disease, the patient was directed to use the following snuff.

℞. Pulv. Nicotian. Tabac., ℥ss.; Cupri Sulphatis, ʒj. M. S. Use as a snuff.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROFESSOR MÜTTER.

Dispensary of Jefferson Medical College, Jan. 25, 1843.

(Reported by H. T. Child.)

LECTURE V.

CASE—*Gelatinous Polypus of the Nose—Operation with forceps.*

Professor M. remarked that when a tumor, especially if it be of a pyriform shape, forms within any of the internal cavities which are lined by mucous membrane, it is termed polypus. It takes its name from an erroneous idea, for a long time entertained, that it had roots or feet similar to those of the sepia or marine polypus, by which it attaches itself to the neighbouring parts.

By far the most common variety of polypus is that which sprouts from the mucous membrane of the nose, and of which there are several varieties. We often, however, meet with similar tumors in the cavity of the antrum, frontal sinuses, larynx, pharynx, œsophagus, meatus auditorius, uterus, vagina and rectum.

Location.—Nasal polypi may occupy any portion of the nostrils, but they usually grow from the upper spongy bones and middle meatus, and for the most part select the outer surface or wall of the cavity. So common, indeed, is it for this portion of the nose to be the seat of the root of the tumor, that Sir A. Cooper declares he has never seen it springing from the septum narium. Sharp, S. Cooper, Cheleus and others, make the same statement; but I have met with an exception to this law in the person of a patient sent me by my friend Dr. Stokes, of Moorestown, N. J.; and Sir Cæsar Hawkins refers to a similar case. The tumor may, therefore, originate in the mucous membrane covering the septum, although, in by far the greater number of cases, it is attached elsewhere.

Form.—The shape of these tumors varies in different cases, inasmuch as it depends almost entirely upon the form of the cavity in which the new growth is contained. Usually in the commencement they are pyriform, oval, or round, but they may become flattened, elongated, lobulated, and finally so irregular as to defy comparison or description.

In nasal polypi where the tumor is single, and points either *forwards* or *backwards*, it is usually pyriform, and flattened by lateral pressure. When, on the other hand, it is composed of several cells, as in the vesicular polypus, its form is irregular and its surface rough: and when it assumes the malignant type, or is malignant from its origin, and, as is usually the case, is fibrous in texture and of large size, it is smooth on the surface, irregular in shape, and attached by a very extensive base, or by false membrane, to the surrounding parts.

Number.—There is great variety in the number of the tumors. In most cases, especially when the polypus is vesicular or gelatinous, we may expect to find more than one; often ten, fifteen, or even twenty may be detected, all held together by loose cellular tissue, and presenting, as a mass, very much the appearance of the ovarium or egg-bag of a fowl: when this is the case one or two large polypi present either at the anterior or posterior opening of the nostril, and prevent the detection of the smaller ones; but as soon as they are removed the latter make their appearance, and often prove a source of great annoyance to one

not accustomed to operating, and who has probably told the patient that one or two introductions of the forceps will be sufficient to eradicate the whole disease. They must all be removed, however, if possible; for if one be allowed to remain it becomes the germ of a new collection, or may itself acquire a large size, and thus give rise to the necessity of a subsequent operation.

Size.—There is also great diversity in size among these nasal polypi; often in the *vesicular form* they are not larger, when first observed, than a small pea, but a number of these, by being attached to each other, may form a mass of considerable size. The gelatinous polypus is usually larger, being from an inch to two inches in length, by an inch or more in width; while the fibrous, although small in its commencement, often acquires an immense volume, destroying as it enlarges, the bones and cartilages by which it is surrounded, extruding the eyeball from its socket, shutting up the fauces, and requiring for its removal one of the most terrific operations ever devised by the surgeon.

Consistence.—These tumors also vary in consistence and texture, and upon this fact one of the classifications of the disease is based. Thus we speak of the *vesicular* or *mucous* polypus, the *gelatinous* (included by Boyer, along with the vesicular, under the single term of *mucous*,) the *fleshy*, the *fibrous*, the *scirrhous*, the *cartilaginous*, and the *osseous*.

Colour.—They vary likewise in colour; the *vesicular* and *gelatinous* being semi-transparent, bluish or whitish, or pale yellow or gray; the fleshy, red or pink; while the fibrous and schirrous are either pale or reddish.

Termination.—They vary also in their tendencies or results; and from this circumstance Mr. Pott particularly urged the doctrine that certain polypi are originally benign, whilst others are malignant. John Bell, whose chief pleasure seems to have been in exciting controversy, and throwing ridicule upon his professional brethren, declares that such an opinion is absurd, inasmuch as all polypi are benign in their commencement, and that, as they increase in size, *all* will terminate, if left to themselves, in the same terrible series of phenomena which belong to the malignant form of the disease. The opinion of Pott, however, is now generally adopted, and I shall take it as the basis of my classification. We may divide all nasal polypi into two groups:

1st. Those which are originally benign, but which may become malignant in process of time.
2d. Those which are originally malignant, and which, depending as they generally do, upon some constitutional taint, run their course rapidly, and invariably produce the most terrible results.

Under the first head I include—1st, the vesicular; 2d, the gelatinous; 3d, the fleshy; 4th, the fibrous; and 5th, the hard polypi.

Under the second—1st, the cancerous of mucous membranes; 2d, the medullary or hæmatoid; 3d, the schirrous.

Polypi have also been divided, according to their location, into *internal* and *external*.

Causes.—The precise causes of the development of nasal polypus have not, as yet, been clearly determined. In most cases it appears to be a strictly local disease, and susceptible of cure by local means alone. In others it evidently depends upon some constitutional affection, and is only to be eradicated by the employment of constitutional as well as topical remedies.

Many local causes, such as picking the nose, taking snuff, mechanical injuries, chronic inflammation of the Shneiderian membrane, ozena, ulcers, scrofula, repeated attacks of cold in the head, &c. &c., have all been cited as directly predisposing to the occurrence of polypus. But, unless chronic inflammation is produced by the first mentioned causes, it seems to me to exert little or no influence; when, however, this action is excited, there can be no question of its laying the foundation of the polypus growth. I have over and again seen chronic inflammation and ozena followed by polypus; and I have also known dyspepsia, by causing chronic inflammation of the mucous membrane of the fauces and nares, give rise to the complaint. Abernethy, Hawkins and others make the same observation.

General Symptoms.—The presence of these tumors in the nostrils, whatever may be their nature, will always give rise to certain general symptoms. The patient usually complains at first of a stuffing of the head, as in common catarrh, which is also accompanied by a secretion of mucous, as in the latter complaint. This attracts little or no attention for some time, but by degrees he finds that he cannot smell so acutely as usual, that his voice is altered, that he is unable to breathe readily when the mouth is closed, and that his taste is also impaired. By and by the tears, provided the polypus points toward the anterior nares, pour over the cheek, in consequence of the obstruction of the ductus ad nasum, and there is likewise an unnatural fulness about the nose.

When the tumor is directed toward the fauces there will be difficulty in deglutition; and when it presses upon the Eustachian tube deafness will result.

Should the individual fail to receive proper assistance at this time, other symptoms are added to those already enumerated; pain of a dull character, unless the disease be malignant, when it is usually sharp and lancinating, now sets in; the patient is drowsy, from the circulation in the brain being interfered with; he is also chilly and indisposed to exertion; the bones of the nose and face enlarge; his skin becomes sallow; his appetite leaves him; there is a discharge of sanious fetid matter from the nostril, sometimes a sudden gush of blood from the opening of a vessel takes place, and the disposition to coma increases. In a few weeks more the poor wretch is reduced to the most terrible condition; in constant agony, with a fetor about him that disgusts and sickens both himself and his friends; with a loathsome secretion constantly poured into his throat, impregnating each morsel of food that he takes; with nearly all his faculties of relation lost, he exhibits a most deplorable example of misery and distress; at length, if mercy, coma, convulsions, or extreme debility end his sufferings and his life. These terrible symptoms are usually confined to the malignant form of the disease; but inasmuch as the benign polypi may degenerate, as it is termed, and become malignant, no case should ever be neglected, or entrusted to the vis medicatrix naturæ alone.

Special Symptoms.—As the prognosis in polypus varies essentially in the different forms of the affection, it is highly important to ascertain the precise character of the tumor before we promise the patient certain relief. And fortunately, the symptoms which characterise each variety are sufficiently obvious to enable us, in most cases, to arrive at a correct diagnosis.

1st. *Vesicular Polypi.*—This form, called by S. A. Cooper *hydatid polypus*, and by Baron Boyer

others, *mucous polypus*, is distinguished by the tumor being composed of a number of greyish semitransparent vesicles held together by cellular tissue, which contain a watery fluid mixed with mucous, and are so soft as to break from the application of very slight force. In removing them this circumstance is very vexatious; for when you expect to get away the whole mass, you find the forceps containing but a few shreds of cellular tissue; and it is impossible to eradicate the disease by any of the usual operations. The influence of the weather on this kind of polypus is very striking; and as this is not so manifest in the other forms, it should be taken into account in the establishment of the diagnosis. In dry weather the patient is often able to breathe with perfect ease; but in a damp atmosphere, which interferes with the evaporation of the secretion from the tumor, he is almost suffocated by the swelling, which often causes the tumor to protrude from the nostril. In this kind, too, the discharge from the nostrils of mucous is much more copious than in the other forms, and generally, although not invariably, the patient is young, and of a feeble constitution. From the softness of the tumor Boyer supposed that it never displaced the bones of the nose, or, at least, where any displacement occurred it was confined to the vomer. This opinion, however, is not correct, for I have seen great deformity produced by it; and the same circumstance has been observed by others. Some difference of opinion as to the precise nature of these tumors exists among authorities. By Garengeot, Heister, Portal, Hawkins, Watson and others, they are supposed to be nothing more than enlargements of the *mucous follicles* of the lining membrane of the nostril; the enlargement depending upon the obstruction of the duct of the follicle, or upon an increase in quantity or change in quality of the mucous secretion itself. This explanation I am disposed to adopt, from the fact that the little sacs or bags which compose the mass are just the shape of the original follicle, and are entirely distinct from each other. Alibert, and other surgeons of authority, on the other hand, believe the tumors to originate in simple serous infiltration of the submucous cellular tissue; but if this were so, instead of the assemblage of separate and regular bags we should have a single tumor, puffy, and presenting the ordinary appearance of œdema anywhere else.

2d. *Gelatinous Polypi.*—This form has been designated by very different appellations. By Fallopius, Severinus and others, it was called the *nasal hemorrhoid*, from its resemblance to the blind pile. Boyer considered it as one form of *mucous polypus*; others called it *membranous polypus*; by Watson it is termed *indurated polypus*; and by Hawkins *gelatinous polypus*. It is characterised by a consistence somewhat similar to that of hard jelly, and hence its present name; but sometimes it is a little firmer, feeling, when compressed, like a raw oyster. It is usually of a dull white colour, covered by a delicate membrane, from which a yellowish mucous is secreted, generally pyriform in shape, and very brittle. It is this tumor that Alibert has described as the *vesicular polypus*; but, in reality, it is a solid mass of mucous membrane, expanded by effusion into its tissue, and not in separate bags, as in the vesicular form. This secretion becomes thicker, and the tissue containing it more and more solid, until at length the polypus is formed.

The gelatinous polypus is usually the result of inflammation, and appears to be much more local in its character than the vesicular, occurring often in healthy persons, and giving rise to little or no constitutional disturbance, at least for a length of time after its development. It usually occupies the middle meatus, and points forwards.

3d. *Fleshy Polypus.*—This tumor is characterised by its vascularity, florid red colour, slight sensibility, unless irritated, firmness, and extensive attachments. It appears that Celsus describes a tumor of this sort, which, according to him, resembled in consistence and appearance the nipple of the female breast.

It has been also referred to by others as the *fungous polypus*. Similar formations are met with in other mucous cavities, especially the urethra, rectum, and meatus auditorius externus. I have repeatedly encountered this affection in the nostril, and in every case have been able to trace the development of the tumor to previous inflammation or ozena. In the case recently sent me by Dr. Stokes, of Moorestown, ozena had evidently produced the polypus. It appears to me, therefore, that such tumors are composed either of organized or coagulable lymph, secreted by the irritated or inflamed Schneiderian membrane, or of fine granulations which sprout from an ulcerated surface.

In the case of Mrs. T. I removed a large mass of what appeared to be coagulable lymph in a state of partial organization, and beneath it, or rather behind it, I detected a mass of fleshy granulations, which yielded to the pressure of the forceps, and could only be eradicated by caustics.

4th. *Fibrous Polypus.*—This is by far the most formidable of all the benign polypi, in consequence of its firmness and disposition to enlarge. It is, therefore, usually, but especially when of long standing, characterised by more or less displacement of the soft parts and bones of the nostril. It is a firm, solid, and highly organized tumor, consisting of true fibrous tissue, and containing very little fluid in its substance. Its colour is reddish white, or pinkish or brownish; and the delicate smooth membrane that covers its surface is studded here and there with patches of coagulable lymph.

It is almost always attached by a pedicle, even more dense and firm than the tumor itself, which usually, though not invariably, occupies the posterior nares, and points towards, or projects into the fauces.

In most cases there is but one tumor, but we may have several; and lastly, it seems confined to adults —children rarely being thus affected. According to Hawkins, Velpeau and others, this kind of polypus has its origin in the fibrous tissue or periosteum and perichondrium that covers the bones and cartilages of the nose, and lies between them and the mucous membrane proper. There is no doubt, however, that a vesicular, or gelatinous, or fleshy polypus may become fibrous by an extension of the morbid action to the periosteum. Indeed, the only difference in these tumors seems to arise from the tissues first involved.

The vesicular originate in disease of the muciperous follicles. The gelatinous and fleshy in disease of the mucous membrane itself; while the fibrous begins in the periosteum, and the mucous membrane becomes subsequently involved. The fact that a soft polypus may be converted into a fibrous or hard one, is another reason why we should never neglect the immediate treatment of a case, however simple it may appear.

5th. *Hard Polypi.*—Under this head I include those tumors in the composition of which either cartilage or bone largely enters; but few cases of this form of polypus have been reported, and in nearly all it would seem that the disease commenced as a

fibrous formation, which subsequently, as is often the case with fibrous tissue elsewhere, becomes converted into cartilage or bone.

(To be continued.)

BIBLIOGRAPHICAL NOTICE.

A Practical and Theoretical Treatise on the Diagnosis, Pathology, and Treatment of Diseases of the Skin, Arranged according to a Natural System of Classification, and preceded by an outline of the Anatomy and Physiology of the Skin. By Erasmus Wilson, Lecturer on Anatomy and Physiology, &c. &c. Philadelphia: Lea & Blanchard. 1843. 8vo. pp. 370.

The pathology of cutaneous diseases, which has so long occupied the French, has recently again attracted the attention of the English, after years of almost entire neglect. The land of Willan and Bateman seemed, until very recently, almost forbidden ground to the Dermatologist.

The earliest classification of diseases of the skin was the very imperfect one of situation. Plenck, of Buda, first classified cutaneous affections from the character of the eruption; and Willan extended and completed the idea in his celebrated nosological arrangement, which has been, with slight modifications, almost universally adopted since, both in Great Britain and in France. The Willanean classification, from its seizing on some one prominent feature as a distinctive character of the disease, bore a striking analogy to the Linnean Classification of the Vegetable Kingdom, and was hence called *artificial.* As by the one a tyro in botany may at once recognise a flower when in full bloom, so by the other the student may readily classify a skin-affection when at its period of full development; but, as in the one case, when the corrolla are yet unexpanded or the stamina have disappeared, the young botanist may be at fault with the Linnean system as his only reliance, so with the youthful Dermatologist, who, in the rise or decline of a disease, will find Willan a very deceptive and uncertain guide. Reflecting on the advantages and disadvantages of the Willanean Classification, and comparing it with the botanical systems in use, the idea struck Mr. Wilson, as he tells us, "that the study of diseases of the skin might be much simplified, and consequently facilitated, by the creation of a system which should embrace all the advantages offered by the Natural System, while it retained the benefits derivable from the Artificial System. It was this thought which gave origin to the system which I have endeavoured to illustrate in the following pages, and for which I have assumed the appellation of—Natural System of Diseases of the Skin." Mr. Wilson does not seem to be aware that 'this self same thought' entered, too, the brain of a Gallic confrére at a period somewhat antecedent. Dr. Charles Martins, Adjunct Professor of the Faculty of Medicine at Paris, ustained this view in a thesis, subsequently published in the Revue Medicale, Tome IV, 1835, entitled "*Les Principes de la Méthode Naturelle appliqués à la classification des maladies de la peau.*"

There is no class of affections in which a classification is so essentially necessary as that of the diseases of the skin. By it the labours of the student are materially abridged, and his inquiries greatly facilitated. Mr. Wilson proceeds in rather a tumid and figurative manner to eulogise this product of a lucky conception, and though his style is not very persuasive or convincing, an examination of his classification satisfies one of its "strength, its simplicity, its easy application, and its truth." The basis of the Natural System of Classification is Anatomy and Physiology. The dermis and its dependencies, its glands and follicles being the seat of all the affections of the skin, Mr. Wilson makes four Primary Divisions, as follows:

I. Diseases of the Dermis.
II. Diseases of the Sudoriparous Glands.
III. Diseases of the Sebaceous Glands.
IV. Diseases of the Hair and Hair Follicles.

The secondary divisions are made with reference to the complex nature of the tissues, or to the perversion of their functions.

The work itself is a very excellent digest of the present state of our knowledge on the diseases of the skin. We do not know that higher pretensions are claimed for it by its author. The student will find it a good manual, and the young practitioner a safe guide.

THE MEDICAL EXAMINER.

PHILADELPHIA, MAY 13, 1843.

MEDICAL OFFICERS OF THE NAVY.

To appreciate how lowly medical service is estimated we must look at the duties performed by other officers and the salaries they receive, as well as the relative position assigned them by the regulations and usage of the navy. If we were to carry the comparison into civil life, perhaps the contrast would be equally striking.

Let us compare the career of a medical officer with that of a purser in the navy.

The duties performed by pursers require for their efficient discharge men who have a fair counting-house education, as far as the art and mystery of book-keeping is concerned, and a general knowledge of trade, that is, of buying and selling goods advantageously. The system of book-keeping adopted in the navy is of the simplest kind, a knowledge of which may be acquired in two or three weeks; and, as a general rule, the whole duty falls upon the purser's steward, now called purser's clerk; in fact, the affairs of his office require rather a general superintendence than attention to details. Such was the case, even when his salary was made up by a per cent. profit on goods of various kinds, sold to the men on board ship for their use, when it might be supposed personal interest would prompt a strict personal attention to affairs made up of many details. But since they receive an annual pay, it is probable they will be better able to delegate more of the duty to the clerk, for which, of course, the purser himself will be responsible to the government. This responsibility is guarantied by two or more securities to the amount of $25,000. As the expenditure of all monies for a ship, the pay of the officers

and crew, provisions and clothing of the men, (the issue of rations,) falls within their province, the pecuniary responsibilities of pursers are very great; hundreds of thousands passing through their hands in the course of a year. The corps of pursers is a highly respectable body of gentlemen; instances of defalcation are almost unknown amongst them. But, notwithstanding their responsibilities and respectability, their relative position in the service is not very much better than that of surgeons, though it is far superior to that of all other medical officers.

By the law of August, 1842, pursers receive a yearly compensation as follows:

Pursers under 5 years standing when on leave of absence,	$1000
" over 5 and under 10 years standing,	1200
" over 10 and under 15 " "	1400
" over 15 and under 20 " "	1600
" over 20 years,	1800
When on duty, on a ship-of-the-line at sea,	3573
" " on a frigate or razee at sea,	3073
" " on a sloop of war and first class steamer,	2073
" " on a brig or schooner, or second class steamer,	1573
" " at the navy yard Boston, New York, Norfolk or Pensacola,	2500
" " at the navy yard Portsmouth, Philadelphia and Washington,	2000
" " at other naval stations in the United States,	1500
" " on receiving ships at Boston, New York and Norfolk,	2500
" " on receiving ships at other places,	1500

This compensation is probably not more than enough to reward them for the $25,000 bonds, and their professional services. Although there is no law to prevent the youngest purser in the navy from being assigned to a ship-of-the-line, it is not likely to occur, because there is a sort of tacit understanding that they must render service progressively from the small to the large vessels. Perhaps it might be safe to say that pursers, for the first five years, serve in brigs and schooners; for the second, in sloops of war; for the third, in frigates; and after that in ships-of-the-line; so that a purser will rarely be ordered to a line-of-battle-ship until after he has been fifteen years in the navy. But after ten years they may be assigned probably to either of the larger receiving vessels or navy yards.

Let us suppose two individuals, say at the age of twenty-five, to enter the navy on the same day; one leaving a book-keeper's situation in a counting house or store, with a purser's commission; the other quitting the place of resident physician in a hospital, or even fresh from the University, to serve as an assistant surgeon. Let us compare the position they occupy in the service, and the compensation received by them, and we may find how much medical education is undervalued by the government, or over estimated by the profession.

The purser enters upon his career with an annual pay of $1000, while unemployed; but the assistant surgeon, under the same circumstances, receives $650. Both may be, perchance, assigned for duty on board of the same sloop of war. The purser takes possession of one of the two best state-rooms in the ward-room, with an annual pay of $2073, and enjoys the same comforts, personal consideration, naval etiquette, and social position, as the lieutenants of the vessel; and in point of lodgement is better off than the surgeon. But the assistant surgeon, with his collegiate honours and his professional qualifications, stamped by the highest test in the country, is allowed a place to hang up his hammock or cot in the steerage, and is assigned to the companionship of midshipmen, boys of from fourteen years and upwards, and his annual compensation is $1023. While the purser departs from and enters the ship from the starboard side, with the honours of the side, the assistant surgeon passes in and out of the vessel by the larboard, with the midshipmen, stewards and servants, "unnoticed and unsung." And according to the received rules of etiquette, he ought not to pass the purser without the salute of touching his hat, because his position in the vessel is a subordinate one to all those who inhabit the ward-room. When both are on the quarter deck, the purser walks on the starboard side, but if the assistant surgeon goes there he is liable to be told he is trespassing.

Before a physician can receive a surgeon's commission he will have served, on an average, ten years in the navy, as assistant and passed assistant surgeon. Therefore, while he receives $1000 a year on leave, the purser, who entered the navy at the same time with him, will receive $1600 on leave; and while the surgeon, during the same period at sea, receives $1406, the purser will receive $3073; on shore duty the surgeon will receive $1250, but the purser will receive either $2000 or $2500, at one of the navy yards or receiving ships. Therefore, throwing out of the calculation all the disagreeable service which he performs as an assistant surgeon for ten years of his life, in a steerage or cockpit, while the purser has enjoyed the comforts of one of the best sleeping berths in the ward-room, in a pecuniary point of view, at the end of his ten years the medical officer finds his commission to be worth about one-half less than that of the purser who entered the navy on the same day.

Again: if we follow the medical officer and purser in their respective careers, at the end of twenty years from the day on which we have supposed both to enter the navy, we shall find that the purser, on leave, receives $1800, on shore duty $2500, and at sea $3573; or, in other words, the highest pay of his grade; but the surgeon, after the same period in the service, receives, on leave, $1400, on shore duty $1750, at sea $1939, or if, by any chance, he be fleet surgeon, $2173,—in other words, before the surgeon can receive the highest pay of his grade, that is, $1800 on leave, $2250 on shore, and $2773 at sea as fleet surgeon, he must have been thirty years in the navy, and have reached an age not usually calculated to encounter the discomforts of a sea-life in a ward-room. But the purser receives the highest pay of his grade after twenty years service.

It would be, perhaps, invidious to compare the mental qualifications, education, and professional acquirements requisite for the two grades; and it may be sufficient merely to direct attention to this point, to convince any thinking man that the educational qualifications of the surgeon are necessarily of an incomparably higher order than those of the purser. As to their comparative re-

sponsibility in a pecuniary point of view only, that of the purser is more extensive; though, as far as risk of loss is concerned, it is not more than that of the surgeon, who must account for a multitude of perishable and very destructible articles, often amounting to several thousands of dollars in value, for the preservation of which his means are usually very limited. The purser, on the contrary, is in every way assisted and facilitated (and most justly) in guarding against loss in his department, besides being allowed a fair per cent. discount for waste or loss in measuring, weighing, &c. But the surgeon's stores are very apt to be looked upon as a sort of necessary nuisance; and when a store-room is assigned for his use, it is sometimes looked upon rather in the light of a personal favour to himself than as a right. Even in frigates, surgeons have been obliged to stow a part of the medical outfit in their sleeping berth or state-room; and it has never been supposed there can be either waste or loss by weighing or measuring the articles in his keeping.

The following table fairly contrasts the compensation of pursers and medical officers, and will show, at a glance, the comparative money value of the two commissions, both present and prospective, through twenty years.

	On leave.	Shore duty.	At sea.
Purser, first 5 years,	$1000	$1500	$1573
Medical officer, first 5 years, (assistant surgeon,)	650	950	1023
Purser, second 5 years,	1200	2000	2073
Medical officer, second 5 years, (passed assistant surgeon,)	850	1150	1273
Purser, third 5 years,	1400	2500	3073
Medical officer, third 5 years, (surgeon,)	1000	1250	1406
Purser, fourth 5 years,	1600	2500	3573
Medical officer, fourth 5 years, (surgeon,)	1200	1500	1673

Theology is not much better appreciated than medicine in the navy; but one had better serve ten years as chaplain than as assistant surgeon. When unemployed, chaplains receive yearly $800; when on duty on shore $1200, and at sea $1273—their pay not being progressive with years of service.

Professors of mathematics, in point of emolument, are on the same level with chaplains; both grades mess in the ward-room. The professors are usually occupied from two to four hours a-day on board ship, teaching those lower branches of mathematics which are essential to practical navigation; consequently, their professional qualifications are not, necessarily, of the highest order.

Secretaries mess in the ward-room, and receive $1073; their duties require them to write a good hand, and possess a fair English education.

On board of steamers the chief engineer messes in the ward-room, and receives annually $1575; and when on leave, $1200.

Whether medical officers are comparatively better or worse paid than chaplains, professors, secretaries and steam engineers, the reader can now judge for himself.

We have next to compare the career of a medical officer with that of a sea-officer in the navy.

The sea-officer enters the service, say at fifteen years of age, and receives the whole of his professional education at the cost of the government, and is fully supported during the time. At the age of twenty-five, at the same period of life when assistant surgeons are appointed, he receives a lieutenant's commission, and takes his place in the ward-room. When on leave, his yearly pay is $1200; when on shore duty, $1500; and when at sea, $1573. On an average, after serving eighteen years as a lieutenant, he is promoted to be a commander, and takes possession of his own cabin, when his annual pay is, on leave, $1800; on shore duty, $2100; and at sea, $2573. In this grade he serves, on an average, eight years, when he becomes a captain, with an annual pay, on leave, of $2500; on shore duty, $3500; at sea, $3573; and if in command of a squadron, $4073. Therefore, twenty-six after the assistant surgeon enters the navy, the lieutenant, who was commissioned on the same day, reaches the dignity and pay of a captain at the age of fifty-one years. But the medical officer, at the same age, is still in the ward-room, and his pay is $2206, (or, if a fleet surgeon, $2473.)

If a parent had two sons of the same age, both destined to the naval service, one as a sea-officer and the other as a medical officer, he would be charged with the care and education of one until he was fifteen, while the other would be an expense to him till he was twenty-five. And when both were fifty years of age, the son who had cost his father least, would be receiving, on leave, $2500; on shore duty, $3500; and at sea, $3573; while he who laboured most, and whose profession had been at his father's expense, would receive, on leave, $1600; on shore duty, $2000; and at sea, $2206.

It only remains to contrast the pay of medical officers of the navy with those of the army.

	Navy.	*Army.*
Chief of the Medical Bureau,	$2500	$3042
Surgeons of ten years standing,	from $1400 to $2173	From $2519 to $2824
Surgeons of less than 10 years,	from $1000 to $1573	" $1794 to $2227
Assistant surgeons,	from $650 to $1273	" $1083 to $2489

Besides being better paid, the medical officers of the army hold a better position relatively to officers of the line, than medical officers of the navy. Although medical service in the army is more highly appreciated in the army than in the navy, it is very far, in our opinion, from being too highly paid or estimated. None but those who are of the profession can fully understand the long and arduous labour and expense required to make a competent practitioner; and perhaps few persons know the toil, mental anxiety, and, consequently, wear and tear of health and constitution, that the practitioner of medicine and surgery must encounter, whether engaged in civil or military practice. We verily believe, if all these matters were clearly understood, the number of aspirants for medical honours would be very sensibly diminished; particularly if they would take into consideration the fact, which is too generally overlooked, that to be a successful practitioner of medicine, a capital suffi-

cient to maintain a man as a gentleman for at least ten years after graduation is necessary.

The remark of Professor Gibson is probably true, "that the education of members of the profession, if complete, will often consume as much capital as would afford them, without practice, a decent competency."—*Rambles in Europe in* 1839.

At a time when the profession, both in England and the United States, is making efforts to augment its worth, and increase and sustain its respectability, the great body of practitioners ought not to overlook the condition of those members of the profession who are employed in military service, for, by securing their interests they protect themselves. In short, the members of the profession at large, in all parts of the country, are called upon, in professional fellowship, to exercise their influence in behalf of those medical men who serve their country either in the army or navy. Is the profession of medicine to be viewed by the government and by the people as inferior to that of arms, to that of a seamen, to that of a paymaster, or of a purser, and consequently be degraded in position and emolument, while the great mass of practitioners look on, and acknowledge that the science of medicine and surgery is really worth less to the public than the arts of arms or traffic?

Is it not time to teach the world that properly educated members of our profession are equal, in point of worth and respectability, to the members of any other class or calling in the United States? Instruct the people that the term physician does not include homœopathists, thomsonians, hydrosudopathists, electro-magnatists, or any other genus or species of quacks and impostors. If we permit these ignoble and miscalled doctors, by bold assumption, to place themselves upon a level with the legitimate members of the profession in the undiscriminating eye of the public, we deserve the degradation that surely awaits us. But before we can expect success, we must find some means of destroying the quackery that is said to exist among "regularly bred physicians." And perhaps a powerful mode of effecting this purpose would be, to introduce the fashion of cash payments, either for the visit or at the conclusion of the case, which would have the effect of removing temptation to resort to irregular modes of advertising and puffing from needy practitioners. This time seems to be propitious for establishing such a fashion, because in all directions we meet the significant placard, "terms cash," even in places where business was formerly done on the credit system. To those members of the profession whose practice only yields a support, the changing from credit to cash for the wants of themselves and families must be extremely inconvenient, while they are obliged to render their services on credit. And this inconvenience may result in quackery or starvation.

If the cash system were in vogue, as a general rule, physician's bills or fees would be more cheerfully paid than they are now. The services of the medical adviser, rendered in February, are apt to be coldly remembered the following December; and although the patient in the mean time may have paid the highest fees to the most distinguished lawyer, given the highest price for furniture, or dry goods, or wines, or contributed largely to his church, paying high pew rent—in short, paying the highest prices for the means of supplying all his wants and satisfying his tastes, the physician is expected to deduct something from his account at the end of the year. Besides being more advantageous to the physician, to the great majority of his patients it would be more agreeable and convenient to pay his fee daily, or to liquidate his bill at the termination of the case.

But who is to bring about a change that seems to be fraught with so much benefit to the mass of the profession? Can it be done by colleges of physicians or medical societies? Or is it in the power of a few leaders to establish the custom, by setting an example that the less influential members of the profession might follow without risk of losing business?

DISEASE OF MITRAL VALVES.

Mr. Adams communicated a case of disease of the mitral valves. The subject was a gentleman temperate in his habits, but who had formerly suffered repeated syphilitic attacks, for which he had undergone several mercurial courses. About six years ago he began to feel a difficulty of breathing, and afterwards hæmoptysis and palpitations. Three months ago (on the 3rd of September), while turning in his bed, he perceived a remarkable irregularity in the action of the heart. A few weeks back he came to Dublin, and applied for advice to Mr. Adams, who, on examining him, found that his limbs were anasarcous, and there were evident symptoms of a disease of the heart, but it was doubtful whether it were aneurism or disease of the valves. The second sound of the heart was accompanied by a sound like that observed in cases of aneurism. A consultation was then held with Dr. Stokes, who was of opinion that the mitral valves were diseased, and that the death would be very sudden. The treatment adopted consisted in the exhibition of small doses of calomel, squill, and digitalis, together with small bleedings by leeches, which were used in preference to small bleedings from the arm, in consequence of the patient's statement that venesection caused him to faint, and this is objectionable in diseases of the heart. At this time, although the action of the heart was violent, the pulse at the wrist was very weak, the respiration was generally sound, but at night dyspnœa occurred in paroxysms. The death was very sudden; it occurred soon after breakfast, while the patient was on the night-chair. The left ventricle was found to be considerably dilated, and the mitral valves indurated, thickened, and infiltrated with a yellowish material, which, in some parts, was ossified. The appearances were well delineated in a drawing produced by Mr. Adams.—*Dub. Med. Journ.*

TANNIN IN HOOPING COUGH.

M. Sebregondi has found decided benefit from the employment of pure tannin in the asthenic stage of hooping cough. He has administered it in doses of a quarter to half a grain every two hours in conjunction with sedatives, as extract of hemlock, &c., and purgatives, as infusion of senna, under which treatment the paroxysms have entirely ceased in a short time. Any constipating or griping effect of the remedy is corrected by its combination with the above medicines. With respect to the hemlock, it may be added that Dr. Meyer, of Kreutzburg, has found tannin as obtained in infusion of galls an efficient remedy against the poisonous effect of this substance, emetics of sulphate of zinc having been previously employed to empty the stomach.—*Lon. Lancet, from Med. Zeit.*, No. 50.

RETROSPECT OF THE MEDICAL SCIENCES.

OINTMENT OF THE EXTRACT OF NUTGALLS.

Mr. Daniel S. Jones, a recent graduate of the Philadelphia College of Pharmacy, states that when nutgalls are treated with water by the displacement process, they yield 63 per cent. of dry extract, about two-thirds of their weight, and proposes an ointment formed by triturating two scruples of the extract of galls with a little water, and afterwards with seven drams of lard as a substitute for the officinal ointment made with ordinary powdered galls.

When thus made, this ointment embodies all the activity of the nutgalls, without that gritty, uneven character of the ordinary ointment, due to the uneven division of the powder, and which amounts to an objection to its use in some cases of extremely irritable hemorrhoids.

The ointment possessed a perfectly uniform consistence, but was objected to as being too soft. Simple cerate was proposed as a substitute for lard. In the ordinary ointment, the dry bulky nature of the powdered galls compensates for the softness of the lard. In other respects the proposed ointment was approved of as an efficient and eligible preparation.—*Am. Journ. of Pharm.* April, 1843.

THE INDIAN HEMP.

At a meeting of the Medico-Botanical Society of London, March 22d, a communication from Mr. Ley was read detailing the results of his experience with the Cannabis Indica, or Indian hemp, in the treatment of certain convulsive and inflammatory diseases. One of the most important and interesting of the cases detailed by him was that of a lady who had been confined to the hydrostatic bed for five years from disease of the spine and hip, and in whom, whenever she was removed from the bed for the renewal of the India-rubber sheet covering it, there was produced a disturbance, little felt at the time, but inducing at night a succession of violent spasms of the muscles of the spine, drawing the body back into the form of an arch, and as suddenly relaxing. These spasms would follow each other rapidly through the night, producing faintness, sickness, and insensibility, all through the next day. This alternate state of nocturnal tetanus and daily fainting continued, generally, after each moving, for a fortnight or three weeks, obstinately resisting every medicine that could be applied for its relief. When Mr. Ley obtained possession of some of the resinous extract of hemp, he had pills of one grain weight made, of which he gave his patient six, directing her to take one on the occurrence of the first symptom of the spasm, and to repeat the dose every half-hour until the spasm was relieved, or some other reason offered for their discontinuance. Five pills were taken, when she felt overpowered, the muscles relaxed, and she fell into a profoundly tranquil sleep, likened by her afterwards to a trance, because she was for a long time after she had apparently fallen asleep conscious of passing events, but unable to make known her perceptions. The spasmodic attacks returned for several successive nights, but were not so violent nor of such duration as previously. The opinion of this lady, who, from long illness, is familiarised with medicines, is, that the extract of hemp affects the muscles principally, relieves ordinary pains less surely than opium, disturbs the stomach little, if at all, but produces an unpleasant sensation in the head, not excitement, but objects appear before the eyes which do not really exist; thus she may see a book so plainly on her bed as to reach out her hand to take it, or she may seem to be holding a newspaper. Mr. Ley has further found the resinous extract of hemp of service in the treatment of acute rheumatism, cholera, chorea, effusion into the knee-joint, housemaid's-knee, enlarged ganglia, &c.—*London Lancet.* April 1, 1843.

CONCLUSION OF MM. DANGER AND FLANDIN'S RESEARCHES CONCERNING THE EFFECTS OF ARSENIC ON WOOL-COVERED ANIMALS, &c.

1. The sheep that survived after taking four drachms of arsenious acid, having been killed on the thirty-eighth day after, no part of the carcase was found, on the autopsy, to contain a single appreciable trace of arsenic. A dog to which the viscera were given to eat exhibited not the slightest sign of illness, nor could arsenic be detected on analysis either of its fæces or urine; and six persons who partook of the muscular fibre as food lived on it for twelve days without feeling any inconvenience or symptom distinguishing it from meat of other descriptions.

2. The dog that ate the viscera of three poisoned sheep did not experience fatal results, and when killed on the ninth day from the reception of this food, exhibited a healthy internal appearance, without any trace of arsenic whatever, the entire poison having passed off in the urine during the six days immediately following the introduction of the poison into the system. The comparative harmlessness of the poison on the dog, as compared with the sheep, may be accounted for from the far smaller extent (about one fifth) of the intestinal canal, as well as the much greater muscularity of the tissues connected with the digestive organs of the carnivorous animals: these causes render the digestion, absorption, and the secretions generally much more active in the dog than the sheep.—*Ibid, from Gazette des Hôpitaux.*

NAPHTHALINE.

This substance has been employed with success by M. Emery in the treatment of psoriasis and lepra vulgaris, twelve cases out of fourteen in which it was tried having been entirely cured by its use. M. Emery recommends its application to the skin in the form of an ointment composed of from one to two drachms of naphthaline to an ounce of lard. Considerable irritation is sometimes produced; but this seems to be readily allayed by emollient affusion and cataplasms, and the remedy usually effects a cure in a few weeks or months. No particular course of diet is enjoined.—*Ibid, from L'Experience.*

TREATMENT OF SALIVATION.

To combat mercurial salivation, I prefer applying acid. hydrochlor. fort. to the gums and tongue when they are ulceraed, repeating the application every day, or every other day. The bleeding of the surface ought not to be an obstacle. The acute pain it produces soon ceases, and nothing equals its beneficial effects. Of course the peculiar indications which may present themselves must not be neglected.—*M. Ricord on Venereal.*